SERFF Tracking Number:	*QUAC-127912145*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*50532*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005B Individual - Point-of-Service (POS)*
Product Name:	*IQ Choice*		
Project Name/Number:	*Applications/*		

Filing at a Glance

Company: QCA Health Plan, Inc.

Product Name: IQ Choice	SERFF Tr Num: QUAC-127912145	State: Arkansas
TOI: H16I Individual Health - Major Medical	SERFF Status: Closed-Approved-Closed	State Tr Num: 50532
Sub-TOI: H16I.005B Individual - Point-of-Service (POS)	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Jim Couch, Niki Thomas	Disposition Date: 12/21/2011
	Date Submitted: 12/20/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:
State Filing Description:		

General Information

Project Name: Applications	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 12/21/2011
	State Status Changed: 12/21/2011
Deemer Date:	Created By: Niki Thomas
Submitted By: Niki Thomas	Corresponding Filing Tracking Number:
PPACA: Not PPACA-Related	
PPACA Notes: null	
Filing Description:	
Application	

Company and Contact

Filing Contact Information

Jim Couch, VP of Compliance	jim.couch@qualchoice.com
12615 Chenal Parkway, Suite 300	501-228-7111 [Phone] 5118 [Ext]

Little Rock, AR 72211 501-707-6729 [FAX]

Filing Company Information

QCA Health Plan, Inc.	CoCode: 95448	State of Domicile: Arkansas
12615 Chenal Parkway, Suite 300	Group Code:	Company Type: Health Maintenance Organization
Little Rock, AR 72211	Group Name:	State ID Number:
(501) 228-7111 ext. [Phone]	FEIN Number: 71-0794605	

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	2 forms at $50.00 a form.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
QCA Health Plan, Inc.	$100.00	12/20/2011	54699709

SERFF Tracking Number:	*QUAC-127912145*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*50532*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005B Individual - Point-of-Service (POS)*
Product Name:	*IQ Choice*		
Project Name/Number:	*Applications/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/21/2011	12/21/2011

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Filing Letter	Note To Reviewer	Niki Thomas	12/20/2011	12/20/2011

SERFF Tracking Number:	*QUAC-127912145*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*50532*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005B Individual - Point-of-Service (POS)*
Product Name:	*IQ Choice*		
Project Name/Number:	*Applications/*		

Disposition

Disposition Date: 12/21/2011
Implementation Date:
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Reviewed-No Actuary
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*QUAC-127912145*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*50532*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005B Individual - Point-of-Service (POS)*
Product Name:	*IQ Choice*		
Project Name/Number:	*Applications/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	IQ Choice Application	Approved-Closed	Yes
Form	IQ Choice Alternate Application	Approved-Closed	Yes

SERFF Tracking Number:	*QUAC-127912145*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*50532*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005B Individual - Point-of-Service (POS)*
Product Name:	*IQ Choice*		
Project Name/Number:	*Applications/*		

Note To Reviewer

Created By:
Niki Thomas on 12/20/2011 01:27 PM
Last Edited By:
Rosalind Minor
Submitted On:
12/21/2011 12:43 PM
Subject:
Filing Letter
Comments:
VIA SERFF

December 20, 2011

Arkansas Department of Insurance
Life and Health Division
1200 West Third Street
Little Rock, AR 72201-1904

RE: QCA Health Plan, Inc. Filings

Attached to this filing please find QCA Health Plan, Inc.'s filing for updated Applications for the IQChoice product.

Please feel free to contact me at any time should you need additional information or have any questions or comments. Thank you.

Sincerely,

J. Nicole Thomas, J.D.
Associate Corporate Counsel
nicole.thomas@qualchoice.com
(501) 219-5129

SERFF Tracking Number:	*QUAC-127912145*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*50532*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005B Individual - Point-of-Service (POS)*
Product Name:	*IQ Choice*		
Project Name/Number:	*Applications/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 12/21/2011	0211+UW+022 IQCAppl(12/11)	Application/ Enrollment Form	IQ Choice Application	Initial			IQChoice_Application_2012.pdf
Approved-Closed 12/21/2011	1211+UW+003_IQCAltApp	Application/ Enrollment Form	IQ Choice Alternate Application	Initial			IQChoice_Alternate_Application_2012.pdf

Application for Individual Health Insurance

Please read the following instructions for completing this application:

- The policyholder or the oldest applicant must be between the ages of 19-64, and a legal resident of Arkansas and the United States.
- If application is approved, the policyholder is responsible to notify QualChoice in writing of **any** changes to the information provided on your application before the policy 'effective' date. Failure to do so may result in QualChoice rescinding coverage to the original effective date.
- This application is a legal document and will become part of your contract if you are approved for coverage. You must provide **all** requested information and ensure it is accurate and legible.
- Please ensure that all required parties sign and date the application. A digital signature is available on the writeable PDF.
- In answering the questions in this application, do not include any family medical history or information related to genetic testing, services or counseling. Also, do not include any information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information.
- We strongly encourage you to save a copy to your computer or make a photocopy of this completed application for your records.
- This application is a writeable PDF. You can complete by saving to your computer. **If you do not have the latest version of Adobe Reader, please visit adobe.com for a free download.** You can also print the application. Please complete in either black or dark blue ink.
- **For Printed Applications Only:**
  - ✓ Please mark through the incorrect information, initial it and then provide the correct information.
  - ✓ Do not use correction fluid or correction tape to correct any mistakes you make.
  - ✓ Any attached sheets containing additional information must be signed and dated by the applicant.
  - ✓ Please do not send money with this application.

Once the IQChoice application has been completed, you can submit by:

ONLINE APPLICATION	FAX PRINTED APPLICATION	MAIL PRINTED APPLICATION
Complete at **www.myiqchoice.com** **Fill out online, no mailing required.**	**Fax: 866.645.1788**	**QualChoice** **ATTN: IQChoice** **P.O. Box 26208** **Little Rock, AR 72221**

Policy Effective Date

The policy effective date will be the 1st of the month following the month in which the application for coverage is approved. Coverage becomes effective upon the date of the policy and contingent upon receipt of premium.

Application for Individual Health Insurance

1. WHO IS APPLYING

In the RELATIONSHIP box below, please indicate spouse, son, daughter, stepson, or stepdaughter beside each dependent's name. **Please submit immunization records for all dependents one (1) year old or less. IMPORTANT:** Stepchildren who apply for coverage must reside with the proposed insured. If any other dependents named on this application do NOT reside with the proposed insured, we must also have the custodial parent's signature. If a guardianship or custodial relationship exists, please attach appropriate court documents.

FIRST NAME	M.I.	LAST NAME	SUFFIX	RELATIONSHIP	SEX	BIRTH DATE	SOCIAL SECURITY NUMBER	HEIGHT	WEIGHT
								__ft__in	____lb
								__ft__in	____lb
								__ft__in	____lb
								__ft__in	____lb
								__ft__in	____lb

2. MARITAL STATUS

☐ Single (including widowed and divorced) ☐ Married (including separated)

3. U.S. CITIZENSHIP STATUS

☐ Yes ☐ No Are all applicants U.S. citizens?

If NO, please provide the name(s) of the applicant(s) who are **not** U.S. citizens.

Applicant (list all that apply): _____

Applicants who are not U.S. citizens will be required to complete a Foreign National Questionnaire prior to the processing of their application. Please contact the IQChoice Sales Manager at 866.645.1790 to request the Foreign National Questionnaire.

4. RESIDENTIAL ADDRESS (No P.O. Box, please)

PERMANENT RESIDENCE STREET ADDRESS	CITY	STATE	ZIP

5. MAILING ADDRESS (Complete only if **different** from residential address)

MAILING STREET ADDRESS	CITY	STATE	ZIP

6. BILLING ADDRESS (Complete only if **different** from residential address)

BILLING STREET ADDRESS	CITY	STATE	ZIP

7. HOUSEHOLD INFORMATION

☐ Yes ☐ No Do all applicants reside in the same household?

If NO, provide reason: _____

☐ Yes ☐ No Do all applicants reside in Arkansas?

If NO, provide reason and address: _____

8. CONTACT INFORMATION

PRIMARY PHONE NUMBER	SECONDARY PHONE NUMBER	BEST TIME TO CALL
		☐ AM ☐ PM

9. EMAIL INFORMATION (Complete by each applicant who is 18 years of age or older)

IMPORTANT DECISION: I want to do my part for the environment and reduce waste. By checking "**Yes**", I agree that QualChoice can deliver all documents, notices and any other communications with respect to my IQChoice application and/or coverage electronically to my email address above. This includes, but is not limited to, my Insurance **Certificate of Coverage**, all explanation of benefits describing how my claims have been adjudicated, billing invoices, renewal notices, and any other communications. I understand I can change my mind at any time and revoke my decision to have these documents and communications sent to me electronically simply by contacting IQChoice at **1.866.645.1790**. I also understand that I can ask QualChoice at any time to provide me with any of these documents in paper form by regular mail. I agree to contact QualChoice if my email address changes so that these important documents, notices and communications will come to my new email address.

Applicant: _____ EMAIL Address: _____ ☐ **Yes** ☐ **No**
Applicant: _____ EMAIL Address: _____ ☐ **Yes** ☐ **No**
Applicant: _____ EMAIL Address: _____ ☐ **Yes** ☐ **No**
Applicant: _____ EMAIL Address: _____ ☐ **Yes** ☐ **No**

10. EMPLOYMENT INFORMATION

Applicant: _____ Employer: _____ Occupation: _____
Job Duties: _____ ☐ Yes ☐ No Is this applicant covered under workers' compensation?

Applicant: _____ Employer: _____ Occupation: _____
Job Duties: _____ ☐ Yes ☐ No Is this applicant covered under workers' compensation?

11. DRIVER'S LICENSE INFORMATION

Applicant: _____ License Number: _____ State Issued: _____
Applicant: _____ License Number: _____ State Issued: _____
Applicant: _____ License Number: _____ State Issued: _____

☐ Yes ☐ No Has any applicant had his/her driver's license suspended within the past two (2) years?
☐ Yes ☐ No Has any applicant had his/her driver's license revoked within the past two (2) years?
☐ Yes ☐ No Has any applicant been convicted or charged with driving under the influence of alcohol or a controlled substance within the past five (5) years?

If YES, to any of the above questions, please provide the following information:

Applicant: _____ Violation: _____ Date of Occurrence: _____
Applicant: _____ Violation: _____ Date of Occurrence: _____

12. SPORTING OR HOBBY INFORMATION

☐ Yes ☐ No Does any applicant intend to: pilot a private aircraft, race a motor vehicle, boat, or snowmobile, participate in sky diving, ballooning, mountain climbing, hang gliding; or any other hazardous sport, hobby, or activity?

Applicant: _____ Please Explain: _____
Applicant: _____ Please Explain: _____

13. TRAVEL OUTSIDE OF THE UNITED STATES

☐ Yes ☐ No Is any applicant planning to travel or work outside of the **United States** for more than thirty (30) days within the next two (2) years?

If YES, please provide the following information:

Applicant (list all that apply): _____ Country: _____
Reason for Travel: _____ Expected Length of Stay: _____

14. PREVIOUS INSURANCE EXPERIENCE INFORMATION

☐ Yes ☐ No Has any applicant ever been declined for the issue of life, accident, or health insurance?

If YES, please provide the following information:

Applicant: _____ Year: _____ Carrier: _____ Reason for Decline: _____
Applicant: _____ Year: _____ Carrier: _____ Reason for Decline: _____
Applicant: _____ Year: _____ Carrier: _____ Reason for Decline: _____

15. CURRENT INSURANCE INFORMATION

☐ Yes ☐ No Has any applicant been covered by an insurance health plan within the past 63 days?

If YES, and the **coverage** has a specified termination date, please provide it here: _____/_____/20_____

☐ Yes ☐ No Has any applicant ever been covered by QualChoice or QCA Health Plan, Inc.?

☐ Yes ☐ No Are any applicants eligible for an employer-sponsored group health plan?

☐ Yes ☐ No Are any applicants covered by Medicare/Medicaid? ☐ Medicare ☐ Medicaid

If "yes", please provide the reason for coverage:

_____

16. EXPECTANT/ADOPTIVE PARENT INFORMATION

☐ Yes ☐ No Is any **male** applying for coverage an expectant parent or potential adoptive parent?

☐ Yes ☐ No Is any **female** applying for coverage an expectant parent or potential adoptive parent?

If YES to either question above, please provide the following information:

Applicant: _____ Expected Delivery/Adoption Date: _____

17. TOBACCO USAGE INFORMATION

☐ Yes ☐ No Has any applicant used **any** form of tobacco within the last five (5) years?

If YES, please provide the following information:

Applicant: _____ Year Began: _____ Type Used: _____ Amount Used Per Day: _____

Applicant: _____ Year Began: _____ Type Used: _____ Amount Used Per Day: _____

Applicant: _____ Year Began: _____ Type Used: _____ Amount Used Per Day: _____

18. PRESCRIPTION QUESTIONNAIRE

☐ Yes ☐ No Is any proposed applicant **currently** taking any prescription medication or has any applicant taken prescription medication in the **last three (3) years**?

If YES, please provide full detail in Section 22. Additional Medical Questionnaire. Use a separate sheet if necessary. **Any attachment must include the same information requested here and must be signed and dated.** A pharmacy print out is **not** acceptable. **Please use the name that would have been given at the time of the prescription – e.g., a maiden name may have been used.**

Person Treated	Name of Prescription	Dosage	Specific Condition/Illness	Start Date/ Stop Date	Degree of Recovery			Physician Name & Address
					None	Partial	Full	

19. Physician Information

☐ Yes ☐ No Has any applicant seen a physician in the **last two (2) years**?

If YES, please provide the name, address, and phone number of each applicant's physician (group applicants with the same physician together).

Applicant(s)	Physician Name	Physician Address	Physician Phone Number	Date & Reason of Last Visit

20. OPTIONAL BENEFIT RIDERS

Check "Yes" or "No" for the optional benefit riders you wish to add to your benefit plan.

☐ Yes ☐ No Maternity (Pregnancy). Rejection of the maternity rider means that covered benefits will not include coverage for maternity.

If YES, please provide name of physician: _____

☐ Yes ☐ No Temporomandibular Joint Disorder (TMJ). Rejection of the TMJ rider means that covered benefits will not include coverage for temporomandibular joint disorder or craniomandibular disorder.

If YES, please provide name of dentist and physician:

Dentist: _____ Physician: _____

☐ Yes ☐ No Mental Health. Rejection of the mental health rider means that covered benefits will not include coverage for mental health conditions.

If YES, please provide name of physician: _____

☐ Yes ☐ No Creditable Coverage. Rejection of the creditable coverage rider means that you will have a twelve (12) month waiting period of all pre- existing conditions. (Pre-existing conditions do not apply to dependent children under age 19)

If YES, send Certificate of Creditable Coverage to: IQChoice, P.O. Box 26208, Little Rock, AR 72221.

QualChoice will not process application until Certificate of Creditable Coverage has been received.

Please Tear Off and Keep For Your Records

FAIR CREDIT REPORTING ACT NOTICE
NOTICE TO PROPOSED INSURED

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to QualChoice. Forward your written request to QualChoice, ATTN: Individual Underwriting Division, P.O. Box 26208, Little Rock, AR 72221.

21. MEDICAL QUESTIONNAIRE

In answering the questions in this application, do not include any family medical history or information related to genetic testing, services or counseling. Also, do not include information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information.

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE. For each question checked below, give full details in the ***ADDITIONAL MEDICAL INFORMATION*** section, which follows.

1. Has any Applicant ever had or been told he/she had: **(Each question must have a "Yes" or "No" box checked.)**

A. BRAIN OR NERVOUS SYSTEM

Yes No

- ☐ ☐ Alzheimer's disease or other dementia
- ☐ ☐ Autism
- ☐ ☐ Cerebral Palsy
- ☐ ☐ Fainting, Dizziness, Vertigo
- ☐ ☐ Lou Gehrig's disease (ALS)
- ☐ ☐ Migraine headaches
- ☐ ☐ Multiple Sclerosis, Muscular Dystrophy or Myasthenia Gravis
- ☐ ☐ Neuroma / Abnormal nerve growth
- ☐ ☐ Neuropathy or Neuritis
- ☐ ☐ Paralysis or Palsy
- ☐ ☐ Parkinson's disease
- ☐ ☐ Polio
- ☐ ☐ Polyneuritis
- ☐ ☐ Seizures, epilepsy, other convulsions
- ☐ ☐ Spina Bifida

B. CIRCULATORY

Yes No

- ☐ ☐ Anemia
- ☐ ☐ Chest pain, shortness of breath (SOB), heart murmur, palpitations, rheumatic fever
- ☐ ☐ Cholesterol/Lipids Abnormal
- ☐ ☐ Coronary artery disease, Pulmonary artery disease, atherosclerosis, stent and/or angioplasty
- ☐ ☐ Heart attack, angina, heart pain
- ☐ ☐ Heart surgery, Pacemaker implant
- ☐ ☐ Hemophilia or other blood clotting
- ☐ ☐ High blood pressure (HTN)
- ☐ ☐ Sickle-cell anemia or Thalassemia
- ☐ ☐ Stroke (cerebral vascular accident), including TIA (transient ischemic attack)
- ☐ ☐ Any other condition of the heart, blood vessels or circulatory system

C. DIGESTIVE

Yes No

- ☐ ☐ Cirrhosis of liver or other liver disorders
- ☐ ☐ Diverticulitis, Polyps, Hemorrhoids
- ☐ ☐ Gastric bypass surgery or other weight loss surgery
- ☐ ☐ Gastric reflux (GERD) or Pyloric stenosis
- ☐ ☐ Hepatitis
- ☐ ☐ Hernia
- ☐ ☐ Irritable bowel disease
- ☐ ☐ Pancreatitis
- ☐ ☐ Ulcerative colitis, Crohn's disease
- ☐ ☐ Ulcers of the stomach or intestine
- ☐ ☐ Any other condition of stomach, intestines, gall bladder, liver or rectum, GI bleeding, anal fissure

D. KIDNEY, URINARY, REPRODUCTIVE

Yes No

- ☐ ☐ Abnormal pap smear
- ☐ ☐ Any other condition of the kidneys or urinary tract
- ☐ ☐ Cesarean section or miscarriage
- ☐ ☐ Dialysis
- ☐ ☐ Kidney failure, disease, syndrome
- ☐ ☐ Kidney or bladder stones
- ☐ ☐ Sugar, blood or protein in urine
- ☐ ☐ Prostate condition, any other male reproductive system condition
- ☐ ☐ Breast or ovary issues, any other female reproductive organ issues

E. RESPIRATORY

Yes No

- ☐ ☐ Asthma, Allergies with or without shots
- ☐ ☐ COPD –Chronic obstructive pulmonary disease, Chronic bronchitis, emphysema
- ☐ ☐ Pleurisy
- ☐ ☐ Reactive or obstructive airway disorder
- ☐ ☐ Sleep apnea
- ☐ ☐ Tuberculosis
- ☐ ☐ Any other lung, bronchial tube or respiratory system disorder

F. CANCERS, LYMPH, BLOOD OR SKIN

Yes No

- ☐ ☐ Acne or Eczema
- ☐ ☐ Anemia
- ☐ ☐ Burns of the skin, throat, or lungs
- ☐ ☐ Cancer
- ☐ ☐ Hodgkin's disease / Lymphoma
- ☐ ☐ Leukemia
- ☐ ☐ Malignancy of any kind
- ☐ ☐ Melanoma of any location
- ☐ ☐ Neoplasm or tumor of any kind
- ☐ ☐ Any other condition of the lymph system
- ☐ ☐ Any other condition of the skin

G. GLANDULAR DISORDERS

Yes No

- ☐ ☐ Adrenal disorder
- ☐ ☐ Cushing's disease
- ☐ ☐ Diabetes, abnormal blood sugar (glucose)
- ☐ ☐ Goiter
- ☐ ☐ Growth hormone deficiency
- ☐ ☐ Hyperthyroidism
- ☐ ☐ Hypothyroidism
- ☐ ☐ Any disorder of pancreas
- ☐ ☐ Any disorder of thyroid, pituitary, adrenal or other glands

H. MUSCULOSKELETAL

Yes No

- ☐ ☐ Arthritis / Osteoarthritis
- ☐ ☐ Back / Neck pain, Sciatica
- ☐ ☐ Carpal tunnel syndrome
- ☐ ☐ Chronic fatigue
- ☐ ☐ Connective tissue disorder
- ☐ ☐ Fibromyalgia / Arthralgia
- ☐ ☐ Fracture(s) or broken bone; Exposed Bone: ☐ Y ☐ N
- ☐ ☐ Gout
- ☐ ☐ Lupus, systemic
- ☐ ☐ Osteoporosis / Osteopenia
- ☐ ☐ Rheumatoid arthritis
- ☐ ☐ Spinal curvature or other deformity
- ☐ ☐ TMJ disorder
- ☐ ☐ Any other condition affecting the muscles, bones or joints, including chiropractic care

I. EAR/EYES/NOSE/THROAT

Yes No

- ☐ ☐ Cataracts or Glaucoma
- ☐ ☐ Cleft lip or palate
- ☐ ☐ Ear infection / Otitis Media
- ☐ ☐ Meniere's disease
- ☐ ☐ Nasal septal defect
- ☐ ☐ Sinusitis or Tonsillitis
- ☐ ☐ Any other condition of the eyes, ears, nose, or throat

J. MENTAL/ EMOTIONAL OR SUBSTANCE ABUSE

Yes No

- ☐ ☐ ADD / ADHD
- ☐ ☐ Anxiety, depression, panic attacks
- ☐ ☐ Attempted suicide
- ☐ ☐ Counseling/Psychiatric Treatment /Rehabilitation
- ☐ ☐ Drug or alcohol abuse
- ☐ ☐ Eating disorder
- ☐ ☐ Psychiatric treatment
- ☐ ☐ Schizophrenia / Paranoia
- ☐ ☐ Any other mental, emotional disorder or situation

K. OTHER

Yes No

- ☐ ☐ AIDS or AIDS related complex or HIV infection
- ☐ ☐ Amputations or other implant, prosthetic device, internal fixation device or retained hardware (i.e., pins, screws)
- ☐ ☐ Breast Implants: If YES: ☐ Saline ☐ Silicone
- ☐ ☐ Collagen disease
- ☐ ☐ Current patient in a hospital or nursing home
- ☐ ☐ Sarcoidosis
- ☐ ☐ Surgery, procedure, or test (explain in "Additional Medical information")
- ☐ ☐ Surgery, procedure, or test suggested but **not** completed
- ☐ ☐ Transplant recipient
- ☐ ☐ Any injury, deformity, incapacitation, disease or condition not listed elsewhere

22. ADDITIONAL MEDICAL INFORMATION

Give full details to questions answered affirmatively (checked or answered "yes") to explain answers to questions in Medical Questionnaire. In addition to condition/illness, please provide the type of treatment provided or planned – for example, surgery, X-rays, EKG, lab tests, hospitalization, emergency room visit, nursing home confinement, doctor visits, rehabilitation services, occupational therapy, physical therapy, speech therapy or chiropractic treatments. Please ensure you include all the treatments that apply. **Use a separate sheet if necessary. Any attachment must include the same information requested here and must be signed and dated.** Please use the name that would have been given **at the time of the medical service — e.g., a maiden name may have been used.**

Section Letter: _____Condition/Illness: _____

Applicant: _____

Severity of Condition: ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Is this condition chronic?

☐ Yes ☐ No Is applicant currently under treatment for this condition?

_____ If YES, what is the treatment and how often?

☐ Yes ☐ No Was there more than one episode of symptoms?

_____ If YES, how many episodes have occurred?

☐ Yes ☐ No Has applicant had surgery?

_____/_____ If YES, when was the surgery (MM/YYYY)?

_____ If YES, what type of surgery?

____/_____ If NO, date of last treatment (MM/YYYY)?

☐ Yes ☐ No Is the cause of the condition known?

_____ If YES, what is the cause?

_____/_____ Most recent test reading (if applicable)

Please list all medication related to this condition and any other information that may be applicable (such as where, when, how).

_____

_____

_____

_____

Section Letter: _____Condition/Illness: _____

Applicant: _____

Severity of Condition: ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Is this condition chronic?

☐ Yes ☐ No Is applicant currently under treatment for this condition?

_____ If YES, what is the treatment and how often?

☐ Yes ☐ No Was there more than one episode of symptoms?

_____ If YES, how many episodes have occurred?

☐ Yes ☐ No Has applicant had surgery?

_____/_____ If YES, when was the surgery (MM/YYYY)?

_____ If YES, what type of surgery?

____/_____ If NO, date of last treatment (MM/YYYY)?

☐ Yes ☐ No Is the cause of the condition known?

_____ If YES, what is the cause?

_____/_____ Most recent test reading (if applicable)

Please list all medication related to this condition and any other information that may be applicable (such as where, when, how).

_____

_____

_____

_____

Section Letter: _____Condition/Illness: _____

Applicant: _____

Severity of Condition: ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Is this condition chronic?

☐ Yes ☐ No Is applicant currently under treatment for this condition?

_____ If YES, what is the treatment and how often?

☐ Yes ☐ No Was there more than one episode of symptoms?

_____ If YES, how many episodes have occurred?

☐ Yes ☐ No Has applicant had surgery?

_____/_____ If YES, when was the surgery (MM/YYYY)?

_____ If YES, what type of surgery?

____/_____ If NO, date of last treatment (MM/YYYY)?

☐ Yes ☐ No Is the cause of the condition known?

_____ If YES, what is the cause?

_____/_____ Most recent test reading (if applicable)

Please list all medication related to this condition and any other information that may be applicable (such as where, when, how)

_____

_____

_____

_____

Section Letter: _____Condition/Illness: _____

Applicant: _____

Severity of Condition: ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Is this condition chronic?

☐ Yes ☐ No Is applicant currently under treatment for this condition?

_____ If YES, what is the treatment and how often?

☐ Yes ☐ No Was there more than one episode of symptoms?

_____ If YES, how many episodes have occurred?

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_____/_____ If YES, when was the surgery (MM/YYYY)?

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_____ If YES, what is the cause?

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Please list all medication related to this condition and any other information that may be applicable (such as where, when, how).

_____

_____

_____

_____

PLEASE READ BEFORE SIGNING

I UNDERSTAND: (1) This application may be rejected, therefore, that I should not cancel any coverage I currently have until I am notified of QualChoice's decision. (2) If accepted, the insurance applied for shall not become effective until the date shown on my identification card and the initial premium is paid in full, but in no event will insurance become effective earlier than 10 days after the date of this application. (3) The agent or broker involved in this insurance transaction may receive compensation from QualChoice for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker. (4) In addition to other exclusions and limitations, **no QualChoice benefits will be available for 12 months for the treatment of any condition which existed before the effective date of my coverage, unless creditable coverage is applicable. (Pre-existing conditions do not apply to dependent children under age 19)** (5) If my application is accepted relying on my representations on this document, any coverage which may be issued to me shall be invalid if based on false information. (6) My signature authorizes QualChoice to coordinate benefits under this policy with other insurance I have which is subject to coordination. (7) **QualChoice may phone or email me for additional information that may help with the timely processing of my application**.

IN SIGNING BELOW, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded; (b) am responsible to notify QualChoice in writing of **any changes** to the information provided on my application before the policy 'effective' date; (c) authorize any physician, medical practitioner, hospital, clinic or other medically related facility, employer, health plan, the Medical Information Bureau (MIB), insurance or reinsurance company or any third party engaged by QualChoice to secure medical or non-medical information having information with respect to any physical or mental condition, treatment or any non-medical information on me, or any member of my family (if applicable), to give QualChoice or its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (d) authorize all said sources to give such records or knowledge to any agency employed by QualChoice to collect and transmit such information in order to facilitate its rapid submission; (e) agree that this authorization shall be valid without time limit; (f) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request; (g) authorize the Office of Driver Services to release my traffic violation record to QualChoice; and (h) QualChoice may release any information obtained by it about me or any member of my family to MIB or any member company for purposes described in QualChoice's Notice of Privacy Practices.

I ACKNOWLEDGE my understanding that consistent with the requirements of the **Genetic Information Nondiscrimination Act of 2008**, QualChoice does not use genetic information for underwriting purposes or any other purpose prohibited by applicable law. I also acknowledge that QualChoice has requested that in answering the questions in the attached application I do not include any family medical history or information related to genetic testing, genetic services or genetic counseling. Also, QualChoice has requested that I do not include information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information. I further acknowledge that QualChoice has directed me to omit or remove from the attached application any genetic information.

I certify that I signed this application in the state of Arkansas.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

This authorization must be signed by each applicant who is 18 years of age or older.

SIGNATURE SECTION (Please sign appropriate line only)

Proposed Insured's Signature **OR** Parent's/Legal Guardian's Signature **(required if applying)**	**X**	Date Signed
Spouse's Signature **(required if applying)**	**X**	Date Signed
Adult Signature	**X**	Date Signed

THIS SECTION TO BE COMPLETED BY BROKER/AGENT

☐ Yes ☐ No	To the best of your knowledge, will the coverage applied for replace or change any existing hospital, medical, or major medical insurance if this coverage is approved by QualChoice and accepted by the applicant?	
Broker/Agent License #	Broker/Agent Name (Please Print) **X**	Telephone Number
Agency Federal Tax ID # (If applicable)	Broker/Agent Signature **X**	Date Signed
Broker Agency Name	Broker/Agent E-mail	

IMPORTANT:

We cannot process your application without this completed form.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of my enrollment in the policy, I authorize any medical professional, medical care institution, other provider of health care services or supplies, the Medical Information Bureau (MIB), reinsurer, health plan, consumer reporting agency, other third party medical and/or pharmaceutical databases or other organization, institution or person, that has any records on me or my health to provide QualChoice, or its reinsurers, information concerning services or supplies provided to me or to any family member listed on my application. I authorize any prior insurance carrier to furnish information concerning me and/or my family members listed on my application. I understand that information obtained as a result of this authorization will be used for the purpose of underwriting and determining eligibility for coverage. This information shall also be used by QualChoice in investigating and adjudicating claims for benefits. I understand that in the course of their business operations, QualChoice may disclose this information to others as required or permitted by law and as set out in the QualChoice Notice of Privacy Practices. I understand that information provided under this authorization if re-disclosed will no longer be protected. However, QualChoice and its associates are protected by federal and state privacy laws and regulations. I specifically authorize QualChoice to release necessary information obtained by QualChoice about me and any family members listed in my application to my broker or agent. This authorization permits release of information related to substance use or abuse, but does not provide for the disclosure of psychotherapy notes as defined in 45 CFR § 164.501. I acknowledge that signing this authorization is a condition of my enrollment for health coverage by QualChoice. I understand that I may terminate this authorization by sending a written revocation to QualChoice, ATTN: IQChoice, P.O. Box 26208, Little Rock, AR 72221. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. A photocopy of this authorization is valid as the original. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signature in Global and National Commerce Act 15 USC §§ 7001 *et seq*., the Arkansas Electronic Records and Signature Act A.C.A §§25-31-101 *et seq*. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 *et seq*. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

This authorization must be signed by each applicant who is 18 years of age or older.

	X	
Print Name	Signature	Date
	X	
Print Name	Signature	Date
	X	
Print Name	Signature	Date
	X	
Print Name	Signature	Date
	X	
Print Name	Signature	Date

Alternate IQChoice Application

INSTRUCTIONS:
If you are submitting an application from another carrier as a substitute for the *IQChoice Application for Health Insurance*, please complete, sign, and submit: Section I: Who Is Applying, Section II: Medical Questionnaire, Section III: Authorization and Signature and the completed alternate application.

SECTION I: WHO IS APPLYING

In the RELATIONSHIP box below, please indicate spouse, son, daughter, stepson, or stepdaughter beside each dependent's name. **Please submit immunization records for all dependents one (1) year old or less. IMPORTANT:** Stepchildren who apply for coverage must reside with the proposed insured. If any other dependents named on this application do NOT reside with the proposed insured, we must also have the custodial parent's signature. If a guardianship or custodial relationship exists, please attach appropriate court documents.

FIRST NAME	M.I.	LAST NAME	SUFFIX	RELATIONSHIP	GENDER	BIRTH DATE	SOCIAL SECURITY NUMBER

GO GREEN! Do your part for the environment and reduce waste.

By checking "**Yes**" below, I agree that QualChoice can deliver all documents, notices and any other communications with respect to my IQChoice application and/or coverage electronically to my email address above. This includes, but is not limited to, my Insurance **Certificate of Coverage**, all explanation of benefits describing how my claims have been adjudicated, billing invoices, renewal notices, and any other communications. I understand I can change my mind at any time and revoke my decision to have these documents and communications sent to me electronically simply by contacting IQChoice at **1.866.645.1790**. I also understand that I can ask QualChoice at any time to provide me with any of these documents in paper form by regular mail. I agree to contact QualChoice if my email address changes so that these important documents, notices and communications will come to my new email address.

	Name of Applicant	**Email Address (Please PRINT legibly)**
☐ **Yes** ☐ **No**		
☐ **Yes** ☐ **No**		
☐ **Yes** ☐ **No**		
☐ **Yes** ☐ **No**		

OPTIONAL BENEFIT RIDER

Check "**Yes**" or "**No**" for the optional benefit rider if you wish to add it to your benefit plan.

☐ Yes ☐ No Creditable Coverage. Rejection of the creditable coverage rider means that you will have a twelve (12) month waiting period of all pre- existing conditions. (Pre-existing conditions do not apply to dependent children under age 19). If YES, send Certificate of Creditable Coverage to: IQChoice, P.O. Box 26208, Little Rock, AR 72221.
QualChoice will not process application until Certificate of Creditable Coverage has been received.

Please Tear Off and Keep For Your Records

FAIR CREDIT REPORTING ACT NOTICE TO PROPOSED INSURED

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to QualChoice. Forward your written request to QualChoice, ATTN: Individual Underwriting Division, P.O. Box 26208, Little Rock, AR 72221.

SECTION II. MEDICAL QUESTIONNAIRE

In answering the questions in this application, do not include any family medical history or information related to genetic testing, services or counseling. Also, do not include information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information.

ALL OF THE FOLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.

For each question checked below, give full details in ***(L) ADDITIONAL MEDICAL INFORMATION***.

1. Has any applicant ever had or been told he/she had: **(Each question must have a "Yes" or "No" box checked.)**

A. BRAIN OR NERVOUS SYSTEM

Yes No

- ☐ ☐ Alzheimer's disease or other dementia
- ☐ ☐ Autism
- ☐ ☐ Cerebral Palsy
- ☐ ☐ Fainting, Dizziness, Vertigo
- ☐ ☐ Lou Gehrig's disease (ALS)
- ☐ ☐ Migraine headaches
- ☐ ☐ Multiple Sclerosis, Muscular Dystrophy or Myasthenia Gravis
- ☐ ☐ Neuroma / Abnormal nerve growth
- ☐ ☐ Neuropathy or Neuritis
- ☐ ☐ Paralysis or Palsy
- ☐ ☐ Parkinson's disease
- ☐ ☐ Polio
- ☐ ☐ Polyneuritis
- ☐ ☐ Seizures, epilepsy, other convulsions
- ☐ ☐ Spina Bifida

B. CIRCULATORY

Yes No

- ☐ ☐ Anemia
- ☐ ☐ Chest pain, shortness of breath (SOB), heart murmur, palpitations, rheumatic fever
- ☐ ☐ Cholesterol/Lipids Abnormal
- ☐ ☐ Coronary artery disease, Pulmonary artery disease, atherosclerosis, stent and/or angioplasty
- ☐ ☐ Heart attack, angina, heart pain
- ☐ ☐ Heart surgery, Pacemaker implant
- ☐ ☐ Hemophilia or other blood clotting disorder
- ☐ ☐ High blood pressure (HTN)
- ☐ ☐ Sickle-cell anemia or Thalassemia
- ☐ ☐ Stroke (cerebral vascular accident), including TIA (transient ischemic attack)
- ☐ ☐ Any other condition of the heart, blood vessels or circulatory system

C. DIGESTIVE

Yes No

- ☐ ☐ Cirrhosis of liver or other liver disorders
- ☐ ☐ Diverticulitis, Polyps, Hemorrhoids
- ☐ ☐ Gastric bypass surgery or other weight loss surgery
- ☐ ☐ Gastric reflux (GERD) or Pyloric stenosis
- ☐ ☐ Hepatitis
- ☐ ☐ Hernia
- ☐ ☐ Irritable bowel disease
- ☐ ☐ Pancreatitis
- ☐ ☐ Ulcerative colitis, Crohn's disease
- ☐ ☐ Ulcers of the stomach or intestine
- ☐ ☐ Any other condition of stomach, intestines, gall bladder, liver or rectum, GI bleeding, anal fissure

D. KIDNEY, URINARY, REPRODUCTIVE

Yes No

- ☐ ☐ Abnormal pap smear
- ☐ ☐ Any other condition of the kidneys or urinary tract
- ☐ ☐ Cesarean section or miscarriage
- ☐ ☐ Dialysis
- ☐ ☐ Kidney failure, disease, syndrome
- ☐ ☐ Kidney or bladder stones
- ☐ ☐ Sugar, blood or protein in urine
- ☐ ☐ Prostate condition, any other male reproductive system condition
- ☐ ☐ Breast or ovary issues, any other female reproductive organ issues

E. RESPIRATORY

Yes No

- ☐ ☐ Asthma, Allergies with or without shots
- ☐ ☐ COPD –Chronic obstructive pulmonary disease, Chronic bronchitis, emphysema
- ☐ ☐ Pleurisy
- ☐ ☐ Reactive or obstructive airway disorder
- ☐ ☐ Sleep apnea
- ☐ ☐ Tuberculosis
- ☐ ☐ Any other lung, bronchial tube or respiratory system disorder

F. CANCERS, LYMPH, BLOOD OR SKIN

Yes No

- ☐ ☐ Acne or Eczema
- ☐ ☐ Anemia
- ☐ ☐ Burns of the skin, throat, or lungs
- ☐ ☐ Cancer
- ☐ ☐ Hodgkin's disease / Lymphoma
- ☐ ☐ Leukemia
- ☐ ☐ Malignancy of any kind
- ☐ ☐ Melanoma of any location
- ☐ ☐ Neoplasm or tumor of any kind
- ☐ ☐ Any other condition of the lymph system
- ☐ ☐ Any other condition of the skin

G. GLANDULAR DISORDERS

Yes No

- ☐ ☐ Adrenal disorder
- ☐ ☐ Cushing's disease
- ☐ ☐ Diabetes, abnormal blood sugar (glucose)
- ☐ ☐ Goiter
- ☐ ☐ Growth hormone deficiency
- ☐ ☐ Hyperthyroidism
- ☐ ☐ Hypothyroidism
- ☐ ☐ Any disorder of pancreas
- ☐ ☐ Any disorder of thyroid, pituitary, adrenal or other glands

H. MUSCULOSKELETAL

Yes No

- ☐ ☐ Arthritis / Osteoarthritis
- ☐ ☐ Back / Neck pain, Sciatica
- ☐ ☐ Carpal tunnel syndrome
- ☐ ☐ Chronic fatigue
- ☐ ☐ Connective tissue disorder
- ☐ ☐ Fibromyalgia / Arthralgia
- ☐ ☐ Fracture(s) or broken bone; Exposed Bone: ☐ Y ☐ N
- ☐ ☐ Gout
- ☐ ☐ Lupus, systemic
- ☐ ☐ Osteoporosis / Osteopenia
- ☐ ☐ Rheumatoid arthritis
- ☐ ☐ Spinal curvature or other deformity
- ☐ ☐ TMJ disorder
- ☐ ☐ Any other condition affecting the muscles, bones or joints to include chiropractic care

I. EAR/EYES/NOSE/THROAT

Yes No

- ☐ ☐ Cataracts or Glaucoma
- ☐ ☐ Cleft lip or palate
- ☐ ☐ Ear infection / Otitis Media
- ☐ ☐ Meniere's disease
- ☐ ☐ Nasal septal defect
- ☐ ☐ Sinusitis or Tonsillitis
- ☐ ☐ Any other condition of the eyes, ears, nose, or throat

J. MENTAL/ EMOTIONAL OR SUBSTANCE ABUSE

Yes No

- ☐ ☐ ADD / ADHD
- ☐ ☐ Anxiety, depression, panic attacks
- ☐ ☐ Attempted suicide
- ☐ ☐ Counseling / Psychiatric Treatment / Rehabilitation
- ☐ ☐ Drug or alcohol abuse
- ☐ ☐ Eating disorder
- ☐ ☐ Psychiatric treatment
- ☐ ☐ Schizophrenia / Paranoia
- ☐ ☐ Any other mental, emotional disorder or situation

K. OTHER

Yes No

- ☐ ☐ AIDS or AIDS related complex or HIV infection
- ☐ ☐ Amputations or other implant, prosthetic device, internal fixation device or retained hardware (i.e., pins, screws)
- ☐ ☐ Breast Implants: If YES: ☐ Saline ☐ Silicone
- ☐ ☐ Collagen disease
- ☐ ☐ Current patient in a hospital or nursing home
- ☐ ☐ Sarcoidosis
- ☐ ☐ Surgery, procedure, or test (explain in "Additional Medical information")
- ☐ ☐ Surgery, procedure, or test suggested but **not** completed
- ☐ ☐ Transplant recipient
- ☐ ☐ Any injury, deformity, incapacitation, disease or condition not listed elsewhere

SECTION II. MEDICAL QUESTIONNAIRE (cont'd)

L. ADDITIONAL MEDICAL INFORMATION: Give full details to questions answered affirmatively (checked or answered "yes") to explain answers to questions in Medical Questionnaire. In addition to condition/illness, please provide the type of treatment provided or planned – for example, surgery, X-rays, EKG, lab tests, hospitalization, emergency room visit, nursing home confinement, doctor visits, rehabilitation services, occupational therapy, physical therapy, speech therapy or chiropractic treatments. Please ensure you include all the treatments that apply. **Use a separate sheet if necessary. Any attachment must include the same information requested here and must be signed and dated.** Please use the name that would have been given **at the time of the medical service — e.g., a maiden name may have been used.**

Section Letter: _____Condition/Illness: _____

Applicant: _____

Severity of Condition: ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Is this condition chronic?

☐ Yes ☐ No Is applicant currently under treatment for this condition?

_____ If YES, what is the treatment and how often?

☐ Yes ☐ No Was there more than one episode of symptoms?

_____ If YES, how many episodes have occurred?

☐ Yes ☐ No Has applicant had surgery?

_____/_____ If YES, when was the surgery (MM/YYYY)?

_____ If YES, what type of surgery?

____/_____ If NO, date of last treatment (MM/YYYY)?

☐ Yes ☐ No Is the cause of the condition known?

_____ If YES, what is the cause?

_____/_____ Most recent test reading (if applicable)

Please list all medication related to this condition and any other information that may be applicable (such as where, when, how).

_____

_____

_____

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Please list all medication related to this condition and any other information that may be applicable (such as where, when, how).

_____

_____

_____

_____

SECTION III: AUTHORIZATION AND SIGNATURE

I, AUTHORIZE QualChoice to use the attached application as a substitute for the **IQChoice Application** including all questions and answers related to medical conditions, treatment and use of prescription drugs. The undersigned understands submission of attached application containing a materially false statement, misrepresentation or omission may constitute insurance fraud and may result in termination or rescission of coverage. The undersigned also understands the statements below replace any statement of understanding in the attached application.

I UNDERSTAND: (1) This application may be rejected, therefore, that I should not cancel any coverage I currently have until I am notified of QualChoice's decision. (2) If accepted, the insurance applied for shall not become effective until the date shown on my identification card and the initial premium is paid in full, but in no event will insurance become effective earlier than 10 days after the date of this application. (3) The agent or broker involved in this insurance transaction may receive compensation from QualChoice for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker. (4) In addition to other exclusions and limitations, ***no QualChoice benefits will be available for 12 months for the treatment of any condition which existed before the effective date of my coverage, unless creditable coverage is applicable. (Pre-existing conditions do not apply to dependent children under age 19)*** (5) If my application is accepted relying on my representations on this document, any coverage which may be issued to me shall be invalid if based on false information. (6) My signature authorizes QualChoice to coordinate benefits under this policy with other insurance I have which is subject to coordination. (7) **QualChoice may phone or email me for additional information that may help with the timely processing of my application**.

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I certify that I signed this application in the state of Arkansas.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

This authorization must be signed by each applicant who is 18 years of age or older.

Name of Applicant (Print)	Signature of Applicant	Date (MM/DD/YYYY)
	X	
	X	
	X	

IMPORTANT:

We cannot process your application without this completed form.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of my enrollment in the policy, I authorize any medical professional, medical care institution, other provider of health care services or supplies, the Medical Information Bureau (MIB), reinsurer, health plan, consumer reporting agency, other third party medical and/or pharmaceutical databases or other organization, institution or person, that has any records on me or my health to provide QualChoice, or its reinsurers, information concerning services or supplies provided to me or to any family member listed on my application. I authorize any prior insurance carrier to furnish information concerning me and/or my family members listed on my application. I understand that information obtained as a result of this authorization will be used for the purpose of underwriting and determining eligibility for coverage. This information shall also be used by QualChoice in investigating and adjudicating claims for benefits. I understand that in the course of their business operations, QualChoice may disclose this information to others as required or permitted by law and as set out in the QualChoice Notice of Privacy Practices. I understand that information provided under this authorization if re-disclosed will no longer be protected. However, QualChoice and its associates are protected by federal and state privacy laws and regulations. I specifically authorize QualChoice to release necessary information obtained by QualChoice about me and any family members listed in my application to my broker or agent. This authorization permits release of information related to substance use or abuse, but does not provide for the disclosure of psychotherapy notes as defined in 45 CFR § 164.501. I acknowledge that signing this authorization is a condition of my enrollment for health coverage by QualChoice. I understand that I may terminate this authorization by sending a written revocation to QualChoice, ATTN: IQChoice, P.O. Box 26208, Little Rock, AR 72221. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. A photocopy of this authorization is valid as the original. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signature in Global and National Commerce Act 15 USC §§ 7001 *et seq*., the Arkansas Electronic Records and Signature Act A.C.A §§25-31-101 *et seq*. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 *et seq*. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

This authorization must be signed by each applicant who is 18 years of age or older.

Name of Applicant (Print)	**Signature of Applicant**	**Date** (MM/DD/YYYY)
	X	
	X	
	X	
	X	

MAIL COMPLETED FORM TO: IQChoice ▪ PO Box 26208 ▪ Little Rock AR 72221-9917

SERFF Tracking Number:	*QUAC-127912145*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*50532*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005B Individual - Point-of-Service (POS)*
Product Name:	*IQ Choice*		
Project Name/Number:	*Applications/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	12/21/2011
Comments:			
Attachment:			

IQChoice Appliation 2012 Flesch Letter.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	12/21/2011
Bypass Reason:	The Applications for this product are the 2 forms for approval.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	12/21/2011
Bypass Reason:	The Actuarial Justifiation for this product has been previously submitted and approved.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	12/21/2011
Bypass Reason:	The Outline of Coverage for this product has previously been submitted and approved.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	12/21/2011
Bypass Reason:	A PPACA Uniform Compliance Summary is not required for this filing.		
Comments:			

QualChoice®

QualChoice Life and Health Insurance Company, Inc.
QCA Health Plan, Inc.
QualChoice Holdings, Inc.

VIA SERFF

December 20, 2011

Arkansas Department of Insurance
Life and Health Division
1200 West Third Street
Little Rock, AR 72201-1904

RE: QCA Health Plan, Inc's Application filing

Dear Ms. Fowler:

This certifies that the following IQ Choice Applications do not meet the minimum score of forty (40) on the Flesch reading ease test as specified in Ark. Stat. Ann. §23-80-206:

0211+UW+022_IQCAppl(12/11)
1211+UW+003_IQCAltApp

Although the score is lower than the minimum required, it should be approved in accordance with Ark. Stat. Ann. §23-80-207 and warranted due to the nature of the policy form and necessary inclusion of medical terminology and language drafted to conform to state and federal law.

Please feel free to contact me at any time should you need additional information or have any questions or comments.

Sincerely yours,

J. Nicole Thomas, J.D.
Associate Corporate Counsel
Nicole.thomas@qualchoice.com
501-219-5129